

CANNON BUILDING 861 SILVER LAKE BLVD., SUITE 203 DOVER, DELAWARE 19904-2467

STATE OF DELAWARE **DEPARTMENT OF STATE**

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DIVISION OF PROFESSIONAL REGULATION

BOARD OF EXAMINERS OF PSYCHOLOGISTS

SUPERVISORY REFERENCE FORM

Date:			
Supervisor:	Phone:	En	nail
Address:			
City:	State:	Zip:	
The Board of Examiners of Psychologists has receive	ed an application for a psychology	license from the applica	nt named below.
Your name has been submitted by the applicant list One Thousand five hundred (1,500) hours (1 year) of			
We would appreciate your providing the Board with sure to verify all hours worked under your supervision		and returning this form d	lirectly to the Board office. Please b
Applicant's Name:			
Address:			
City:	State:	Zip:	

NOTE: The information contained in this document may be released under the Delaware Freedom of Information Act. We encourage each supervisor to be candid and forthright in their evaluation of a candidate for licensure inasmuch as the supervised professional experience must be completed in a manner satisfactory to the Board.

App	Applicant Name					
	VERIFICA	ATION OF EXPERIENCE				
	(Please print or type -	- Use Additional Sheet if Nece	ssary)			
1.	List the place or places where the applicant engaged in professional experience under your supervision. If the site where the actual s of the applicant took place is different, please indicate and clarify. (No Abbreviations)					
2.	List titles, degrees, licenses or certificates you held during supervision of the applicant: (No Abbreviations) Title Degree, Field, Date State License or Certificate Number					
	and Un		Type of License and Date Received			
3.	The applicant's professional identity during their period of supe					
Ο.	The applicant's professional identity during their period of supervision was that of: (Check appropriate identity): Psychologist Registered/Certified Psychologist Registered Psychological Assistant					
	Psychological Intern Trainee Other					
4.	Were you engaged in rendering professional services at least 50% of the time in the same work setting in which the person supervised was obtaining supervised professional experience? Yes No					
5.	Describe below, in detail, the training program and/or psychological duties the applicant performed under your supervision.					

	Dates	Total Number of			Total Number	Total Number of	
	From To M/ D/Y M/ D/ Y	Hours Worked Per Week	Hours of Direct Clinical Service Per Week	Weeks	of Hours Worked Verified	Hours of Direct Clinical Service for Entire Period Verified	
7.	Please provide a detailed breakdown of supervision:						
	Format of Supervision	Hours Per Week					
	Individual						
	Group						
	Other (Please Specify)						
	Total						
8.	I would rate this applicant's performance under my supervision as:						
	Accepta	ble Not Acc	eptable Unabl	e to Evaluate			
9.	The Board of Examiners of Psychologists would appreciate any amplifying information regarding your evaluation in Item #8 above. Please include any other information you consider to be relevant on a separate page.						
	I certify and declare that all	of the foregoing is true					
	COUNTY	9	STATE				
	PROFESSIONAL TITLE						
	SIGNATURE		DATE _				
	PLEASE RETURN COMPL	LETED FORM TO:	Delaware Board (861 Silver Lake E Dover, DE 19904	Blvd., Suite 203	sychologists		

Revised: 8/1/2005

Please indicate all hours worked including supervision: